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A Staff Dialogue on Caring for a Cancer Patient Who Commits Suicide: Psychosocial Issues Faced by Patients, Their Families, and Caregivers

ELIZABETH M. O'SHEA, KATHLEEN C. LINTZ, RICHARD T. PENSON, MICHAEL V. SEIDEN, BRUCE A. CHABNER, THOMAS J. LYNCH, JR.

Hematology-Oncology Department, Massachusetts General Hospital Cancer Center, Boston, Massachusetts, USA

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ABSTRACT

Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital (MGH), founded The Kenneth B. Schwartz Center at MGH. The Schwartz Center is a non-profit organization dedicated to supporting and advancing compassionate health care delivery which provides hope to the patient, support to caregivers, and encourages the healing process. The Center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum during which caregivers discuss a specific cancer patient, reflect on the important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from their fellow staff members.

The case presented was of a 31-year-old man who developed adenocarcinoma of the lung with painful bone metastases. His tumor was unresponsive to treatment and he subsequently committed suicide by shooting himself. The verbatim and subsequent discussion raised a number of issues. Staff were devastated by the violent way that he ended his life. They questioned whether more could have been done to prevent this outcome, yet acknowledged that it mirrored the way he had lived, and were able to discuss the values by which we live and die. Some, but not all, felt that the patient had the right to choose how and when to end his life. The Oncologist 2002;7(suppl 2):30-35

PRESENTATION OF CASE

This case was presented at the Schwartz Center Rounds at Massachusetts General Hospital (MGH) in November of 1997. The Schwartz Center Rounds are a monthly multidisciplinary forum in which caregivers discuss a specific patient with cancer and the important psychosocial issues faced by the patient, family, and caregivers.

In October of 1996, a 31-year-old otherwise healthy white male, R.D., presented to MGH with back pain and lower extremity weakness. He had been in good health until June of 1996, when he first noted some left leg weakness. This weakness was associated with mild episodic thoracic back pain radiating into the abdomen. The pain continued with increasing frequency and severity. He was otherwise asymptomatic with no weight loss or other constitutional symptoms. R.D. had a history of well-controlled type I diabetes mellitus, diagnosed at age 13. He had pathological Q waves on his EKG, but no clear antecedent history of coronary artery disease. He had a distant family history of “cancer,” and described himself as a social drinker and smoker. He lived with his girlfriend and worked as a bartender.
During physical examination, R.D. was anxious and in moderate distress. He was kyphotic and had decreased sensation in approximately T10 on the left and decreased sensation in the left foot. He had marked weakness of hip flexion on the left with an upper motor pattern of weakness in the rest of the left leg but without clonus. Plain films showed a compression fracture of T8. Magnetic resonance imaging revealed multiple spine lesions from T7-T9. The lesions in the vertebral bodies of T7 and T8 extended posteriorly into the canal with compression of the cord. There was a further lesion in L3 with no evidence of spinal canal compression.

CT scans of the abdomen confirmed multiple bony lesions in T7-8 and L3, suggestive of metastatic disease but there was no evidence of further metastases. CT scan of the chest showed a 3.0 × 2.5 cm lobulated mass, located in the superior segment of the left upper lobe. There was also a 3.0 mm nodule in the posterior segment of the right upper lobe.

CT scan-guided bone needle biopsy was performed, diagnosing metastatic adenocarcinoma in the vertebral body of T7. No lung mass biopsy was performed, and it was explained to him that he had primary adenocarcinoma of the lung with metastases to the bone.

R.D. was treated with high-dose steroids and received emergent radiation therapy to his thoracic spine. With radiation therapy and decadron, there was some initial improvement in his symptoms. However, after approximately 2 weeks of radiation therapy, he had worsening lower-extremity weakness. Consequently, at the end of October of 1996, R.D. was taken to the operating room for a decompressive laminectomy with resection of epidural tumor and rod stabilization. This was uncomplicated and confirmed metastatic non-small cell lung cancer. A bone scan revealed a further lesion in the left femur. Due to fear of femur fracture, proximal femur resection and prosthesis placement were performed. This was complicated postoperatively by a femoral venous thrombosis. Despite anticoagulation, this resulted in marked swelling of his leg. In April of 1997, following two cycles of carboplatin and taxol, new pulmonary nodules were noted on chest CT. Treatment was discontinued, and R.D. was referred for consideration of strontium radioisotopic treatment for his painful bone metastases.

In March of 1997, he was referred to a psychiatric clinical nurse specialist for evaluation in the community. Socially, his behavior was punctuated with outbursts of anger and crying. Despite these episodes which significantly impacted his family, he refused to see a psychiatrist. He was having difficulty quitting smoking. His mother was deceased and, throughout his illness, his father remained in jail for tax evasion. His girlfriend, however, lived with him and supported him during his difficult clinical course.

In the month before his death, R.D.’s performance status was extremely poor. He was on high doses of narcotics which were escalating daily. He was reviewed in clinic on April 15th and required an ambulance for transportation. On April 17th, with no warning and after his girlfriend had left for work, R.D. took out a gun he had hidden in his home and killed himself with a single shot to the head.

**Dialogue**

**Doctor:** R.D.’s case had a dramatic and unpredicted outcome. We were all shocked and very upset by it. Should we have done something more for him in terms of support? Should we have provided better pain control? Or was it an inevitable and unavoidable outcome? R.D.’s case was very unsatisfying and distressing.

**Social Worker:** Was his psychological state evaluated at any point during his treatment?

**Doctor:** He never gave us any reason to believe that he was intending to take his life. He never mentioned it. He was an avid Patriots fan and he talked about future games that he was going to attend, and he was planning a trip to Hong Kong. He never gave any indication that he was contemplating suicide. We were all in shock when it happened, especially the significant other who he lived with. None of us had any clue. No, we did not discuss suicide with him. Should it have been discussed? I do not know.

**Nurse:** How was his pain control?

**Doctor:** He wanted to remain alert. So his pain control was not as perfect as we would have liked, but I do not think that was the main precipitant.

**Nurse:** Do you know where he got the gun from?

**Doctor:** The gun sat in his end table next to his bed. None of us were aware that he had one, but his personality type was such that it did not surprise me that he had one at home. Is that something that we should have known? I do not know. He was a very controlling man, and I think he wanted this to be his last act of control.

**Nurse:** I was wondering if he had consulted hospice care. Perhaps they could have helped avoid this situation. Should they have been aware of his situation?
Doctor: Hospice was involved in his care at home toward the end. They practically lived at his house. But they were shocked, too. He did not give anyone a clue.

Palliative Care Specialist: When something like this happens, people get upset, and they search for some sort of answer or resolution. It is natural to wonder if you could have done something more.

Doctor: R.D. was very impulsive. I do not think any of us had the foresight to predict this outcome. I do not know if something could have been done differently in this case. He had a reasonable support system in place, but apparently it failed him.

Doctor: Did the support system fail him? Are we sure this was a bad thing? My father-in-law took his life with a gun in the setting of symptomatic metastatic renal cell carcinoma. Most of his family was relieved that his suffering was not prolonged and looked at his final act as courageous and not particularly violent or tragic.

Psychiatrist: It’s not a failure of the system. If people really want to commit suicide, in most cases they can and will. R.D. had enough oral narcotics in the house to kill himself in a peaceful way. But I think he wanted to do this in a particular, controlled way.

Doctor: He clearly wanted what little bit of control over what life he had left. The advanced stage of his cancer was clearly the ultimate blow to his dignity.

Doctor: How are you trying to deal with his suicide? Do you feel bad about it?

Doctor: While I am saddened by his death, I cannot say that I feel that guilty about it because I really do not think that there was anything I could have done. But his girlfriend, who provided total care to him, was very upset and felt cheated. She was not able to say goodbye to him.

Nurse: Her reaction was one of anger because they had had such a strong relationship. They were very close, but he never told her about his thoughts or plans to commit suicide. So she was very disturbed by his sudden death.

Doctor: But is suicide in an advanced cancer patient necessarily a bad thing?

Doctor: Of course it is. I want my patients to die a peaceful death, not a violent one.

Doctor: His suicide might have been a more peaceful death than dying a slow, painful death in bed.

Nurse: Maybe we can provide a peaceful way for patients to die so that they do not have to make the decision whether or not they can go on.

Doctor: I think what some of us are saying is that we are not so much opposed to the idea of suicide or assisted suicide in an advanced cancer patient, but more that we are uncomfortable with how R.D. killed himself and with the fact that he did not consult anyone or ask for help.

Doctor: What kind of cues should we be looking for in cancer patients, or is this really an unavoidable situation?

Social Worker: We should look for whether the patient still has pleasures in his or her life. Do they still value life? Are they able to live the way they want to? But it can be hard to really know.

Nurse: I had a patient with greatly advanced metastatic colon cancer ask me once how he could kill himself. Like the doctor who spoke previously, I do not think that it is necessarily a bad thing for an advanced cancer patient to want to die. He could not sustain a good quality of life. He could not live his life the way he wanted to; he was in pain, and he was close to the end. So we found ourselves in a very uncomfortable position. On the one hand, we did not think his wanting to die was necessarily a bad thing. We knew that he did not want to live this way.

Philosophically, we agreed with him, but under the law we could not tell him how to kill himself. We kind of got around it by prescribing morphine to him, which he was already on. Philosophically, I do not think we failed him at all. But I will never forget the impact that the news of his death had on me. It just hit me in the chest. I do not understand why, though, because we helped him die peacefully. But I guess it bothered me that his death was premature.

Doctor: If the patient had come to us and expressed suicidal feelings, how should we respond to that cry for help?

Doctor: We would have provided further counseling for him. We could have referred him to a psychiatrist, but we had already discussed that with him, and he was adamant about not seeing a psychiatrist. He wanted to do this in his own way. He certainly had the means to die in a peaceful way.
Nurse: Do we screen for weapons at home?

Nurse: Hospice does screen people who have advocated for suicide or those who have expressed suicidal intentions. But in your own home it is easy to put up a facade that everything is okay, particularly if you know that the gun or the pills will be taken from you. Do we have to be okay with a patient’s choice to commit suicide? Is it up to us to say that they are not rational and that it is not okay for them to make their own decision? Are people able to talk about this?

Social Worker: I do not think that we have to think that it is okay. If a patient wants to make his or her own decision, that is fine. But I do not have to agree with their choice. I think the reason we struggle in a situation like this is because sometimes we do not agree with the patient. However, I do not want to be told that because a patient makes a choice that I have to be okay with it, because I have my own beliefs and values. I believe in the sanctity of life, and I do not think suicide is right.

Nurse: In primary care, if a patient mentions suicide, immediately caregivers intervene; they are referred to a psychiatrist, or hospitalized. But in oncology, if a patient tells us that they are thinking about suicide, we do not have such a strong or immediate reaction. We are in a quandary because we need to take into account the factors of sanctity of life, quality of life, and disease progression. This dilemma creates conflicts and difficult decisions for caregivers.

Nurse: I once had a patient tell me that she had had enough, and she asked me to give her morphine to end it all. I told her that legally I could not help her. But I could totally understand where she was coming from. You cannot respect their wishes because it is illegal, but sometimes you would like to because the suffering is so horrible. Is it worth it to go on when the quality of life is so poor and the pain so intense? When you are that far gone, what are you holding onto?

Social Worker: Just like not everyone grieves in the way Elisabeth Kübler-Ross describes, not everyone dies the way we would like them to. Maybe R.D. did not want to die a peaceful or medical death with pills as we would have liked him to. Maybe he wanted to die a non-medical death. Maybe he was able to preserve some part of his personality by going out with a “bang.”

**DISCUSSION**

Suicide rates in young men have doubled over the past two decades, and half of these suicides are violent [1]. Studies have reported a correlation between gun ownership and firearm suicide. Among industrialized countries, the United States has the highest rates of firearm suicide and homicide, as well as the highest rate of gun ownership.

During this dialogue among caregivers concerning a patient who committed suicide during his treatment for advanced lung cancer, staff recalled the distress they felt at the way in which R.D. ended his life. Many questioned whether they could have done more and whether they had provided R.D. with adequate psychological and medical support. While some appeared to feel guilty about his suicide, others felt that suicide in a patient with advanced cancer can be a “good thing,” or, at least acceptable as an outcome.

During this Schwartz Center Rounds, many staff expressed shock at the sudden death of R.D. and verbalized the concern that when a patient is “successful in taking his life, the chance to resolve the anguish, complete unfinished business, and fulfill his destiny” is lost [2]. It is helpful not only to examine the typical behavior that identifies a patient at risk for suicide, but also to remind ourselves that in the face of intolerable suffering many similar patients chose to live. Psychiatrist Victor Frankl, who survived the concentration camps of World War II, observed that people who felt that life had real purpose and meaning coped with the atrocities and almost certain death while others, for whom life had lost all meaning, quickly succumbed to malnutrition and infection [3]. A sense of purpose and meaning is essential to finding value in living.

Suicidal thoughts and wishes are, in fact, common in cancer patients but few make plans or act on these suicidal ideas. Cancer patients’ suicide rate is only about twice that of the general population [4]. One study that reported only 1 in 3,180 cancer patients committing suicide found that such patients are typically men, with the preferred means of killing themselves being a gun [5]. Though gun-shots are the most common method of suicide in cancer patients, a significant number of staff found the violence of R.D.’s death the most distressing aspect of his case.
They appeared to feel offended at such a brutal and "messy" death and wanted a more peaceful end.

While suicide among cancer patients is rare, it does happen and this increased risk highlights the problems of coping with severe illness and the need for psychological and social support in cancer care [6]. Depression, suicidal ideation, delirium, and severe anxiety are common among cancer patients. When severe, these conditions can increase a patient’s risk of suicide and require immediate intervention [7].

While depression can be an understandable response to a diagnosis of cancer [8], clinical depression is common and treatable and associated with an increased risk for suicide. Important suicide risk factors are listed in Table 1.

Cancer is itself a risk factor and adequate psychological assessment should be proactive. Staff need to screen for and respond to symptoms and signs of depression and attend to contributing factors such as ensuring adequate pain control. Increasingly, liaison psychiatry is an integral part of any cancer-care service. Although a suicide attempt may reflect a decision made in sound mind, it more commonly is a symptom of a serious depression. The patient who seriously wishes to commit suicide may mask feelings of despair, particularly if he or she feels that the means of ending life might be taken away by family or caregivers intent on preventing the suicidal act.

Staff members voiced the full spectrum of feelings and beliefs on suicide in a patient with advanced cancer. Some were comfortable with the conviction that suicide could be a reasonable ending to a difficult illness and that the patient had finally been able to gain control of his or her situation. While killing oneself is usually considered an unethical or illegal act, in a patient with cancer, a number of commentators have considered suicide a rational and understandable act [2]. Other members of the same team felt that a cancer patient’s suicide was the worst possible outcome—a failure of the medical support system—and argued that while suicide can be understandable, suicidal thoughts or a suicide attempt as a reaction against hopelessness and despondency demand treatment and interventions aimed at increasing support, and that there is a clear responsibility to intervene [2].

Feelings of guilt about the death of R.D. were very evident among caregivers. Such feelings among caring professionals are common. When they reflect unattainable standards and unrealistic goals, they can thwart readjustment after a death and may do little to prevent the same situation arising again. Despite being committed and caring, you can be left with the feeling that not enough was done and only see failure when something bad happens. Developing a positive framework for dealing with difficult situations—large elements of which are beyond our control—and ensuring that what can be done is done well, bring a sense of confidence.

**CONCLUSION**

While caregivers expressed a variety of reactions to R.D.’s suicide, they all recognized that he had lived and died on his own terms, in accordance with his own personality and values. How a person values his own life and death are intensely personal. There will always be conflicting views on whether or not suicide is right. Even in the context of the 20th century Western world, with its strong beliefs in self-determination, many caregivers felt uncomfortable with the violent end of R.D.’s life. While staff should pursue the mandate to do everything that can be done to relieve suffering, many aspects of a patient’s suicide are beyond their control.

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